STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/28/25 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Emergency Preparedness survey, Hickory Creek at Franklin was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 36 certified beds. At the time of the survey, the census was 27. Quality Review conducted on 01/30/25	E 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection Report. Hickory Creek at Franklin respectfully requests consideration for desk review for this plan of correction in lieu of post survey revisit.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Operations Plan (EOP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., and no documentation could be found to show the	E 0004	**Deficiency ID: E004** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been**	02/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracie	Oldham	02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Emergency Operations Plan (EOP) was reviewed and updated within the last year. Based on an interview during records review, the MS provided an EOP from (1) his office and (2) the nurse's station. The MS searched the Executive Directors (ED) office and made a phone call to the ED but no additional EOP was located. The two EOP's provided for review each reflected a review date of 01/03/24, over a year old. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present.		**affected by the deficient practice?** - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **-** The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -The administrator reviewed and updated the emergency operations plan including policies and procedures based on the facility and community-based risk assessment. The administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office 3. The nurse's station. Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** -The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency	E 0013	**Deficiency ID: E013** Completion Date: 2/23/25	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

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	Operations Plan (EOP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., and no documentation could be found to show the Policies and Procedures was reviewed and updated within the last year. Based on an interview during records review, the MS provided an EOP from (1) his office and (2) the nurse's station. The MS searched the Executive Directors (ED) office and made a phone call to the ED but no additional EOP was located. The two EOP's provided for review each reflected a review date of 01/03/24, over a year old. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present.		Plan of Correction Text: The facility requests Paper Compliance for this citation. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -The administrator reviewed and updated the emergency operations plan including policies and procedures and the communication plan based on the facility and community-based risk assessment. The administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at the following locations: 1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

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			Administrators Office's 2. Environmental Service's Office 3. The nurse's station. Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

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			bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Operations Plan (EOP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., and no documentation could be found to show the Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the MS provided an EOP from (1) his office and (2) the nurse's station. The MS searched the Executive Directors (ED) office and made a phone call to the ED but no additional EOP was located. The two EOP's provided for review each reflected a review date of 01/03/24, over a year old. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present.	E 0029	**Deficiency ID: E029** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **--** The alleged deficient practice has the potential to affect all facility occupants. No residents were identified.	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

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			-The administrator reviewed and updated the emergency operations plan including policies and procedures based on the facility and community-based risk assessment. The administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office 3. The nurse's station. Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **How the corrective actions will be monitored to ensure the deficient practice will not**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

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			recur, i.e., what quality assurance program will be put into place? --The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility failed to ensure the Emergency Operations Plan (EOP) includes names and contact information for the current staff. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., the facility's staff contact information was not current. In each of the provided EOP's the communication plan did not include an updated list of names and contact information for current staff. The MS stated that the first three names and contact information represented on the list, which included the Executive Director, Director of Nursing and Assistant Director of Nursing, were all incorrect. This finding was acknowledged by the Maintenance Supervisor at the time of records	E 0030	**Deficiency ID: E030** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified.	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

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	review and again at the exit conference with the MS present.		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **-** The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -The administrator reviewed and updated the emergency operations plan including the names and contact information for staff, entities providing services, patient physicians, other facilities, and volunteers. The administrator verified all disaster preparedness manuals are current, updated and accessible . Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office 3. The nurse's station. Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

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			- Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** --The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency Operations Plan (EOP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the	E 0036	**Deficiency ID: E036** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be**	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	01/28/2025

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	Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., and no documentation could be found to show the Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the MS provided an EOP from (1) his office and (2) the nurse's station. The MS searched the Executive Directors (ED) office and made a phone call to the ED but no additional EOP was located. The two EOP's provided for review each reflected a review date of 01/03/24, over a year old. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present.		**accomplished for those residents found to have been affected by the deficient practice?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** **--** The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -The administrator reviewed and updated the emergency operations plan training and testing plan. The administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office 3. The nurse's station. Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures	

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	155442	A. BUILDING -- B. WING	01/28/2025

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			compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** --The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility	E 0041	***Deficiency ID: E041**	02/14/2025

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	failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. The MS reviewed his electronic TELS record and could not find evidence of a 4 hour run test being done on the facilities Propane Fired generator. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present.		**Completion Date: 2/14/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -3 year four hour load test had been completed on 10/17/2023 for the on-site spark ignited natural gas generator. **What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur? -Administrator to in-service maintenance director on locating reports from the prior years in TELS by 2/14/25. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** -Maintenance Director to complete the maintenance QAPI tool monthly x6 months and complete all TELS in tasks timely. QAPI tool will be reviewed during bi-monthly QAPI meeting and actions plans created as needed.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/28/25 Facility Number: 000352	K 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Provider Number: 155442 AIM Number: 100290720 At this Life Safety Code survey, Hickory Creek at Franklin was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 27 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered except for one detached garage which was not sprinklered. Quality Review conducted on 01/30/25		conclusions contained in the Indiana Department of Health's inspection Report. Hickory Creek at Franklin respectfully requests consideration for desk review for this plan of correction in lieu of post survey revisit.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide	K 0341	**Deficiency ID: K341** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.**	02/23/2025

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	equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) on 01/28/25 between 12:35 p.m. and 1:40 p.m., the fire alarm control panel (FACP) door was not locked. The entire lockset from the panel door was missing. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present. 3.1-19(b)		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. - Key lock was placed on the one fire panel located in the nurse's station. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** -Maint. Director to complete in-inservice to ensure the fire panel lock is in place.	

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			How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? - Maint. Director to complete fire panel lock audit weekly x4 weeks, and monthly x3 months. Audit tool to be reviewed during bi-monthly QAPI meeting. Action plans to be created as needed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., no record of a fire drill occurring during the first shift of the second quarter of 2024 could be located. In addition to the paperwork provided, the MS searched his electronic TELS record but was unable to located evidence of the drill occurring.	K 0712	**Deficiency ID: K712** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** - The alleged deficient practice has the potential to affect all facility occupants. No residents were identified.	02/23/2025

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	This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present. 3.1-19(b) 3.1-51(c)		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** -The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -Maint. Director will conduct and document fire drills on each shift at varying times per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** -Administrator to conduct in-service with the maintenance director regarding conducting fire drills at least quarterly on each shift and documenting the drill in TELS. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place? -Maintenance Director to complete the maintenance QAPI tool monthly x6 months and complete all TELS in tasks timely. QAPI tool will be reviewed during bi-monthly QAPI meeting and actions plans created as needed.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., the facility provided documentation for testing of the	K 0918	**Deficiency ID: K918** **Completion Date: 2/23/25** **Plan of Correction Text: The facility requests Paper Compliance for this citation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?-** The alleged deficient practice has the potential to affect all facility occupants. No residents were identified.**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**-The alleged deficient practice has the potential to affect all facility occupants. No residents were identified. -3 year four hour load test had been completed on	02/14/2025

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	emergency generator, however, could not provide documentation of a three year 4 hour test. The MS reviewed his electronic TELS record and could not find evidence of a 4 hour run test being done on the facilities Propane Fired generator. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS present. 3.1-19(b)		10/17/2023 for the on-site spark ignited natural gas generator. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**-Administrator to in-service maintenance director on locating reports from the prior years in TELS by 2/14/25. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**-Maintenance Director to complete the maintenance QAPI tool monthly x 6 months and complete all TELS in tasks timely. QAPI tool will be reviewed during bi-monthly QAPI meeting and actions plans created as needed.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification.	K 0921	***Deficiency ID: K921** **Please see Life Safety Code Waiver Request related to this alleged deficiency.**	06/15/2025

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	Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include: Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25 between 10:20 a.m. and 12:35 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The MS stated that PCREE such as nebulizers, oxygen concentrators, hospital style beds and other electrical medical equipment was present and in use at the facility. The MS stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the			

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	MS present. 3.1-19(b)			